MAILING ADDRESS
STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
P.O. BOX 1139
SACRAMENTO, CA 95812-1139
Form 411-8B (Rev. 5/96)

ATTACH FILING FEE

ENDORSEE SELF TERMINATION NOTICE (TO BE FILED IN TRIPLICATE)

Pursuant to Sections 1627 and 1647 of the Insurance Code

- FOR DEPARTMENT USE ONLY -
EFFECTIVE DATE IS DATE SIGNED, UNLESS VALIDATED OTHERWISE OR MARKED VOID BY THE DEPARTMENT.

TO:
THE INSURANCE COMMISSIONER OF THE STATE OF CALIFORNIA
NOTICE IS HEREBY GIVEN THAT EFFECTIVE FROM THE DATE OF FILING OF THIS NOTICE, I AS THE EMPLOYEE HEREBY TERMINATE MY EMPLOYMENT MADE WITH THE EMPLOYER NAMED BELOW.

CHECK ONE BOX ONLY

- ☐ **(FX)-FIRE AND CASUALTY BROKER-AGENT**
- ☐ **(LX)-LIFE AGENT**
- ☐ **(LA)-LIFE AND DISABILITY ANALYST**

EMPLOYER	EMPLOYEE
ENTER ORGANIZATION'S LICENSE NUMBER	ENTER EMPLOYEE'S LICENSE NUMBER.
LICENSE NUMBER OF ORGANIZATION	LICENSE NUMBER OF EMPLOYEE
EMPLOYER'S NAME	EMPLOYEE'S NAME
MAILING ADDRESS	MAILING ADDRESS
CITY	CITY
STATE AND ZIP CODE	STATE AND ZIP CODE

SIGNATURE OF EMPLOYEE
▶

DATE: _____ (MONTH) _____ (DAY) _____ (YEAR)

PHONE #( ) _____

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